		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0042697

Facility Name: SunBridge Care & Rehab-University

Address: 1095 University Drive (Number) Edwardsville (City) 62025 (Zip Code)

County: Madison

Telephone Number: (618) 656-1081 **Fax #** (618) 656-7083

IDPA ID Number: 850370802-039

Date of Initial License for Current Owners: 6/1/97

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sylvia Moreno **Telephone Number:** (505) 468-4984

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Dean Kiklis
(Title) Vice President of Reimbursement

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds: No Bed Changes

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	122	Skilled (SNF)	122	44,530	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	122	TOTALS	122	44,530	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	30,595	2,908	4,830	38,333	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,595	2,908	4,830	38,333	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.08%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 6/1/97

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 6/1/97 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 32 and days of care provided 2,821

Medicare Intermediary TrailBlazer Health Enterprises, LLC

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	153,126	11,554	827	165,507	45,187	210,694	(1,546)	209,148			1
2	Food Purchase		145,409		145,409		145,409	(55)	145,354			2
3	Housekeeping		(191)	92,514	92,323		92,323		92,323			3
4	Laundry		7,689	67,551	75,240		75,240		75,240			4
5	Heat and Other Utilities			106,478	106,478		106,478	988	107,466			5
6	Maintenance	31,099	4,561	68,290	103,950	9,177	113,127	(13,449)	99,678			6
7	Other (specify):* Please See Attached											7
8	**TOTAL General Services**	184,225	169,022	335,660	688,907	54,364	743,271	(14,062)	729,209			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	1,421,135	113,289	100,640	1,635,064	419,238	2,054,302		2,054,302			10
10a	Therapy		8,999	246,532	255,531		255,531		255,531			10a
11	Activities	39,478	5,942		45,420	11,650	57,070		57,070			11
12	Social Services	38,154		4,461	42,615	11,259	53,874		53,874			12
13	Nurse Aide Training											13
14	Program Transportation							5	5			14
15	Other (specify):* Please See Attached											15
16	**TOTAL Health Care and Programs**	1,498,767	128,230	369,633	1,996,630	442,147	2,438,777	5	2,438,782			16
	C. General Administration											
17	Administrative	69,601		92,134	161,735	17,408	179,143	5,272	184,415			17
18	Directors Fees											18
19	Professional Services			21,894	21,894	(280)	21,614	17,764	39,378			19
20	Dues, Fees, Subscriptions & Promotions			19,065	19,065	280	19,345	436	19,781			20
21	Clerical & General Office Expenses	126,943	16,423	41,700	185,066	37,462	222,528	30,754	253,282			21
22	Employee Benefits & Payroll Taxes			582,722	582,722	(554,512)	28,210	(16,673)	11,537			22
23	Inservice Training & Education			3,055	3,055		3,055		3,055			23
24	Travel and Seminar			11,729	11,729		11,729	6,063	17,792			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			30,259	30,259		30,259	(7,341)	22,918			26
27	Other (specify):* Please See Attached			28,707	28,707		28,707	(28,773)	(66)			27
28	**TOTAL General Administration**	196,544	16,423	831,265	1,044,232	(499,642)	544,590	7,503	552,093			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,879,536	313,675	1,536,558	3,729,769	(3,131)	3,726,638	(6,554)	3,720,084			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SunBridge Care & Rehab-University #0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			23,163	23,163		23,163	40,361	63,524			30
31	Amortization of Pre-Op. & Org.							6,323	6,323			31
32	Interest			57,064	57,064		57,064	(32,216)	24,848			32
33	Real Estate Taxes			54,459	54,459		54,459	4,114	58,573			33
34	Rent-Facility & Grounds			232,392	232,392	3,109	235,501	3,101	238,602			34
35	Rent-Equipment & Vehicles			11,512	11,512	22	11,534	1,275	12,809			35
36	Other (specify):* Please See Attached			166,262	166,262		166,262	11,898	178,160			36
37	**TOTAL Ownership**			544,852	544,852	3,131	547,983	34,856	582,839			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			50	50		50		50			39
40	Barber and Beauty Shops							(1,558)	(1,558)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			68,485	68,485		68,485	1,280	69,765			42
43	Other (specify):* Please See Attache		11,798	10,473	22,271		22,271		22,271			43
44	**TOTAL Special Cost Centers**		11,798	79,008	90,806		90,806	(278)	90,528			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,879,536	325,473	2,160,418	4,365,427		4,365,427	28,024	4,393,451			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(100)	1		4
5	Telephone, TV & Radio in Resident Rooms	(8,082)	6		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(55)	2		13
14	Non-Care Related Interest	(524)	21		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(54)	20		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(3,330)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(20,763)	27		24
25	Fund Raising, Advertising and Promotional	(27)	17		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(93,806)	29		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (126,741)		$	30

OHF USE ONLY								
48		49		50		51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	154,765	SCH VII	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 154,765		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 28,024		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SunBridge Care & Rehab-University

ID# 0042697

Report Period Beginning: 1/1/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Employee Meals	$		1
2	Rental Income			2
3	Personal Laundry Income			3
4	Rebates & Refunds			4
5	Sales Tax on food			5
6	Interest Income			6
7	Alloc Amort - Finance Fees	(10,284)	21	7
8	Alloc Letter of Credit Fees	(24,677)	21	8
9	Alloc Commitment Fees	(340)	21	9
10	Alloc Finance Fees	(711)	21	10
11	Public Relation			11
12	Vending Machine Revenue	(1,446)	1	12
13	Adjust Physical Therapy cost to actual		10a	13
14	Management Fee Exp (Ic00)	(92,134)	17	14
15	Chamber of Commerce	0	20	15
16	Regional Public Relations		20	16
17	Royalty Fees (IC00)		20	17
18	Other Non-Oper Inc		21	18
19	Regional Marketing Director		21	19
20	Cable TV			20
21	Discounts & Rebates	273	21	21
22	Laundry Supplies Refund	(137)	21	22
23	Nursing Supplies Refund	(1,730)	21	23
24	Resident Expenses	(1,683)	27	24
25	Depreciation Expense - Equipment	14,142	30	25
26	Amortization - Leasehold Expense	26,219	30	26
27	RE Tax Accrual	4,114	33	27
28	Barber/Beauty Inc	(1,558)	40	28
29	Patient Personal Services		21	29
30	Pat Personal Svcs Inc		21	30
31	Travel Expense Adjustment coded to wrong bldg.	269	24	31
32	Equip Rental Income		35	32
33	Community Awareness	(5,616)	27	33
34	Special Events	(645)	27	34
35	Miscellaneous Rev	(284)	21	35
36	Miscellaneous Expense (IC00)	(66)	27	36
37	Interest Expense - Interco (IC00)		32	37
38	FAS 121 Charge		21	38
39	Employer Match 401K	(958)	22	39
40	Sales & Use Tax	1,280	42	40
41	Regional Allocation	94,573	17	41
42	Health Insurance	29,358	22	42
43	Worker's Compensation Audit Adjustment		22	43
44	Worker's Compensation Adjustment	(56,610)	22	44
45	Professional & General Liability Adjustment	(8,701)	26	45
46	Property Insurance Adjustment	(37)	26	46
47	Auto Insurance Adjustment	646	26	47
48	Interest Expense	(57,064)	32	48
49	**Total**	(93,806)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(1,546)	0	0	0	0	0	0	0	0	0	0	(1,546)	1
2	Food Purchase	(55)	0	0	0	0	0	0	0	0	0	0	(55)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	988	0	0	0	0	0	0	0	0	0	988	5
6	Maintenance	(8,082)	465	(5,832)	0	0	0	0	0	0	0	0	(13,449)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(9,683)	1,453	(5,832)	0	0	0	0	0	0	0	0	(14,062)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	5	0	0	0	0	0	0	0	0	0	5	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	5	0	0	0	0	0	0	0	0	0	5	16
	C. General Administration													
17	Administrative	2,412	2,860	0	0	0	0	0	0	0	0	0	5,272	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(3,330)	21,094	0	0	0	0	0	0	0	0	0	17,764	19
20	Fees, Subscriptions & Promotions	(54)	490	0	0	0	0	0	0	0	0	0	436	20
21	Clerical & General Office Expenses	(38,414)	69,168	0	0	0	0	0	0	0	0	0	30,754	21
22	Employee Benefits & Payroll Taxes	(28,210)	11,537	0	0	0	0	0	0	0	0	0	(16,673)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	269	5,794	0	0	0	0	0	0	0	0	0	6,063	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(8,092)	751	0	0	0	0	0	0	0	0	0	(7,341)	26
27	Other (specify):*	(28,773)	0	0	0	0	0	0	0	0	0	0	(28,773)	27
28	**TOTAL General Administration**	(104,191)	111,694	0	0	0	0	0	0	0	0	0	7,503	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(113,874)	113,152	(5,832)	0	0	0	0	0	0	0	0	(6,554)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **SunBridge Care & Rehab-University** **# 0042697** **Report Period Beginning:** **1/1/02** **Ending:** **12/31/02**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	40,361	0	0	0	0	0	0	0	0	0	0	40,361	30
31	Amortization of Pre-Op. & Org.	0	6,323	0	0	0	0	0	0	0	0	0	6,323	31
32	Interest	(57,064)	0	24,848	0	0	0	0	0	0	0	0	(32,216)	32
33	Real Estate Taxes	4,114	0	0	0	0	0	0	0	0	0	0	4,114	33
34	Rent-Facility & Grounds	0	0	3,101	0	0	0	0	0	0	0	0	3,101	34
35	Rent-Equipment & Vehicles	0	0	1,275	0	0	0	0	0	0	0	0	1,275	35
36	Other (specify):*	0	10,424	1,474	0	0	0	0	0	0	0	0	11,898	36
37	**TOTAL Ownership**	(12,589)	16,747	30,698	0	0	0	0	0	0	0	0	34,856	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(1,558)	0	0	0	0	0	0	0	0	0	0	(1,558)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	1,280	0	0	0	0	0	0	0	0	0	0	1,280	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(278)	0	0	0	0	0	0	0	0	0	0	(278)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(126,741)	129,899	24,866	0	0	0	0	0	0	0	0	28,024	45

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SunBridge Healthcare Corp.	100%	Please see attached	Please see attached	See 6A	See 6A	See 6A

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Administrative	$	SunBridge Healthcare Corporation	100.00%	$ 2,860	$ 2,860	1
2	V	5	Heat and Other Utilities		SunBridge Healthcare Corporation	100.00%	988	988	2
3	V	6	Maintenance		SunBridge Healthcare Corporation	100.00%	465	465	3
4	V	14	Program Transportation		SunBridge Healthcare Corporation	100.00%	5	5	4
5	V	19	Legal & Accounting		SunBridge Healthcare Corporation	100.00%	21,094	21,094	5
6	V	20	Dues and Subscriptions		SunBridge Healthcare Corporation	100.00%	490	490	6
7	V	21	General Office Expenses		SunBridge Healthcare Corporation	100.00%	69,168	69,168	7
8	V	22	Employee Benefits		SunBridge Healthcare Corporation	100.00%	11,537	11,537	8
9	V	24	Travel		SunBridge Healthcare Corporation	100.00%	5,794	5,794	9
10	V	26	Insurance		SunBridge Healthcare Corporation	100.00%	751	751	10
11	V	36	Depreciation		SunBridge Healthcare Corporation	100.00%	10,424	10,424	11
12	V	31	Amortization		SunBridge Healthcare Corporation	100.00%	6,323	6,323	12
13	V								13
14	Total			$			$ 129,899	$ * 129,899	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		32	Interest	$	SunBridge Healthcare Corporation	100.00%	$ 24,848	$ 24,848	15
16	V		36	Property Taxes		SunBridge Healthcare Corporation	100.00%	1,474	1,474	16
17	V		34	Facility Lease		SunBridge Healthcare Corporation	100.00%	3,101	3,101	17
18	V		35	Equipment Lease		SunBridge Healthcare Corporation	100.00%	1,275	1,275	18
19	V		10,10a	Pharmacy Expense	122,753	SunScript Pharmacy Corporation	100.00%	122,753		19
20	V		10a	Physical,Speech,Occupational Ther	244,469	SunDance Rehabilitation Corporation	100.00%	244,469		20
21	V		6	Software	7,200	Shared Healthcare Systems, Inc.	96.00%	1,368	(5,832)	21
22	V		0,10a,4	Medical Supplies & Equipment Rental	64,653	Medline Industries, Inc.	100.00%	64,653		22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 439,075			$ 463,941	$ * 24,866	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-4984
Fax Number: (505) 468-4969

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	1,499,081,809	263	$ 1,020,747	$ 1,020,747	4,180,216	$ 2,846	1
2	5	Heat and Other Utilities	Accumulated Cost	1,499,081,809	263	333,694		4,180,216	931	2
3	6	Maintenance	Accumulated Cost	1,499,081,809	263	154,646		4,180,216	431	3
4	14	Program Transportation	Accumulated Cost	1,499,081,809	263	1,616		4,180,216	5	4
5	19	Legal & Accounting	Accumulated Cost	1,499,081,809	263	7,475,466		4,180,216	20,845	5
6	20	Dues and Subscriptions	Accumulated Cost	1,499,081,809	263	167,353		4,180,216	467	6
7	21	General Office Expenses	Accumulated Cost	1,499,081,809	263	20,512,541	15,909,093	4,180,216	57,200	7
8	22	Employee Benefits	Accumulated Cost	1,499,081,809	263	3,350,148		4,180,216	9,342	8
9	24	Travel	Accumulated Cost	1,499,081,809	263	1,192,944		4,180,216	3,327	9
10	26	Insurance	Accumulated Cost	1,499,081,809	263	267,967		4,180,216	747	10
11	30	Depreciation	Accumulated Cost	1,499,081,809	263	3,720,281		4,180,216	10,374	11
12	31	Amortization	Accumulated Cost	1,499,081,809	263	2,256,815		4,180,216	6,293	12
13	32	Interest	Accumulated Cost	1,499,081,809	263	8,867,847		4,180,216	24,728	13
14	33	Property Taxes	Accumulated Cost	1,499,081,809	263	499,821		4,180,216	1,394	14
15	34	Facility Lease	Accumulated Cost	1,499,081,809	263	822,568		4,180,216	2,294	15
16	35	Equipment Lease	Accumulated Cost	1,499,081,809	263	420,584		4,180,216	1,173	16
17										17
18		Total from attached Page 8a	Accumulated Cost	18,200					0	18
19										19
20			Total Units =							20
21			1,499,081,809							21
22										22
23										23
24										24
25	TOTALS					$ 51,065,038	$ 16,929,840		$ 142,397	25

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-4984
Fax Number: (505) 468-4969

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost	493,073,864	69	$ 1,626	$ 1,626	4,180,216	$ 14	1
2	5	Heat and Other Utilities	Accumulated Cost	493,073,864	69	6,761		4,180,216	57	2
3	6	Maintenance	Accumulated Cost	493,073,864	69	4,046		4,180,216	34	3
4	14	Program Transportation	Accumulated Cost	493,073,864	69	1		4,180,216		4
5	19	Legal & Accounting	Accumulated Cost	493,073,864	69	29,405		4,180,216	249	5
6	20	Dues and Subscriptions	Accumulated Cost	493,073,864	69	2,748		4,180,216	23	6
7	21	General Office Expenses	Accumulated Cost	493,073,864	69	1,411,619	1,217,648	4,180,216	11,968	7
8	22	Employee Benefits	Accumulated Cost	493,073,864	69	258,887		4,180,216	2,195	8
9	24	Travel	Accumulated Cost	493,073,864	69	290,943		4,180,216	2,467	9
10	26	Insurance	Accumulated Cost	493,073,864	69	427		4,180,216	4	10
11	30	Depreciation	Accumulated Cost	493,073,864	69	5,926		4,180,216	50	11
12	31	Amortization	Accumulated Cost	493,073,864	69	3,595		4,180,216	30	12
13	32	Interest	Accumulated Cost	493,073,864	69	14,126		4,180,216	120	13
14	33	Property Taxes	Accumulated Cost	493,073,864	69	9,442		4,180,216	80	14
15	34	Facility Lease	Accumulated Cost	493,073,864	69	95,210		4,180,216	807	15
16	35	Equipment Lease	Accumulated Cost	493,073,864	69	11,973		4,180,216	102	16
17										17
18										18
19										19
20										20
21			Total Units =							21
22			493,073,864							22
23										23
24										24
25	TOTALS					$ 2,146,735	$ 1,219,274		$ 18,200	25

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Sun Healthcare Group Inc. (Corporate)
Street Address: 101 Sun Avenue NE
City / State / Zip Code: Albuquerque, NM 87109
Phone Number: (505) 468-4984
Fax Number: (505) 468-4969

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Administrative	Accumulated Cost			$	$		$	1
2	5	Heat and Other Utilities	Accumulated Cost							2
3	6	Maintenance	Accumulated Cost							3
4	14	Program Transportation	Accumulated Cost							4
5	19	Legal & Accounting	Accumulated Cost							5
6	20	Dues and Subscriptions	Accumulated Cost							6
7	21	General Office Expenses	Accumulated Cost							7
8	22	Employee Benefits	Accumulated Cost							8
9	24	Travel	Accumulated Cost							9
10	26	Insurance	Accumulated Cost							10
11	30	Depreciation	Accumulated Cost							11
12	31	Amortization	Accumulated Cost							12
13	32	Interest	Accumulated Cost							13
14	33	Property Taxes	Accumulated Cost							14
15	34	Facility Lease	Accumulated Cost							15
16	35	Equipment Lease	Accumulated Cost							16
17										17
18										18
19										19
20			Total Units =							20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Home Office Interest from Page 8-8c										24,848	6
7												7
8												8
9	TOTAL Facility Related						$	$			$ 24,848	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$ 24,848	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number SunBridge Care & Rehab-University **#** 0042697 **Report Period Beginning:** 1/1/02 **Ending:** 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	47,417	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	51,531	2
3. Under or (over) accrual (line 2 minus line 1).	$	4,114	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	54,459	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	58,573	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	41,660	8
	1998	43,034	9
	1999	43,771	10
	2000	48,417	11
	2001	51,531	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SunBridge Care & Rehab-University COUNTY Madison

FACILITY IDPH LICENSE NUMBER 0042697

CONTACT PERSON REGARDING THIS REPORT Sylvia Moreno

TELEPHONE (505) 468-4984 FAX #: (505) 468-4969

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	14-2-15-15-11-201-002.001	1095 University Drive	$ 51,531.03	$ 51,531.03
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 51,531.03	$ 51,531.03

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,290 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	5 TON AC/HEATING UNIT/COMFORT			07/10/97	10,741	1,074	10	1,074		5,908	10
11	ZONELINE HEAT-COOL WALL SYSTEM			06/25/97	1,582	105	15	105		580	11
12	WALL A/C/DIRECT SUPPLY			08/26/97	620	83	5	83		620	12
13	WALL A/C/DIRECT SUPPLY			08/26/97	769	103	5	103		769	13
14	DOOR ALARMS (7)/HEPPTECH			10/08/97	1,139	114	10	114		598	14
15	A/C/DIRECT SUPPLY			09/22/97	849	127	5	127		849	15
16	A/C HEATING UNIT/DIRECT SUPPLY			01/01/98	849	170	5	170		849	16
17	A/C UNIT/DIRECT SUPPLY			01/01/98	849	170	5	170		849	17
18	WALL A/C UNIT/DIRECT SUPPLY			01/01/98	672	134	5	134		672	18
19	A/C UNIT/DIRECT SUPPLY			01/01/98	849	170	5	170		849	19
20	A/C WALL/DIRECT SUPPLY			01/01/98	608	122	5	122		608	20
21	VINYL FLOORING/INTERIOR CON/MO			01/01/98	1,953	195	10	195		977	21
22	A/C HEAT UNITS-2/DIRECT SUPPLY			05/27/98	1,447	145	10	145		663	22
23	P171 - REFURB/WALLPAPER			03/15/98	9,835	1,967	5	1,967		9,507	23
24	P171 - REFURB/DRAPERIES			03/15/98	2,649	530	5	530		2,561	24
25	P171 - REFURB/VINYL FLOOR			03/15/98	4,129	413	10	413		1,996	25
26	P171 - REFURB/LIGHTING			03/15/98	1,307	131	10	131		632	26
27	P171 - PROJECT/ASPHALT PARKING			03/15/98	48,250	4,825	10	4,825		23,321	27
28	P171 - REFURB/CANOPY			03/15/98	4,569	305	15	305		1,472	28
29	P171 - REFURB/WOOD RAILING			03/15/98	1,829	122	15	122		589	29
30	P171 - REFURB/CONTRACTORS FEE			03/15/98	23,551	1,570	15	1,570		7,589	30
31	WTR MIXING VALVE/DIRECT SUPPLY			06/04/98	1,116	112	10	112		512	31
32	SIGN-EXTERIOR LOGO/ACME WILEY			08/11/98	6,343	634	10	634		2,801	32
33	CUBICLE CURTAINS(8)/MULTI			09/08/98	989	198	5	198		857	33
34	HT WATER HEATER/FOX SUPPLY			10/28/98	2,716	272	10	272		1,132	34
35	ROOFING SHINGLES			11/23/98	2,680	268	10	268		1,094	35
36	SINK-KOHLER CLINICAL\DIRECT			12/09/98	802	40	20	40		164	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PAINT ROOMS & WARDS	1/1/1999	$ 6,000	$ 400	15	$ 400	$	$ 1,600	37
38	PAINT HALLWAYS/DOORWAYS	3/9/1999	7,200	1,440	5	1,440		5,520	38
39	FLOOR & WALL MOLDING	4/20/1999	2,337	156	15	156		571	39
40	ANTI-FREEZE LOOP/SMOKING	5/21/1999	6,600	660	10	660		2,365	40
41	REPLACE SIDEWALK	6/15/1999	12,150	810	15	810		2,903	41
42	REPLACE ROOFING	8/4/1999	7,000	700	10	700		2,392	42
43	Comp/Phone Cabling Upgrade	10/1/1999	3,460	346	10	346		1,125	43
44	Wood Doors	10/1/1999	2,575	172	15	172		558	44
45	HEAT/COOL UNIT	5/12/2000	617	123	5	123		329	45
46	ELECTRIC WATER HEATER	6/6/2000	2,721	272	10	272		703	46
47	ROOF COVERING	1/1/2001	74,180	4,945	15	4,945		9,891	47
48	DOOR LOCK SYSTEM	2/12/2001	1,851	185	10	185		355	48
49	VINYL FLOORS	3/20/2001	13,944	1,394	10	1,394		2,440	49
50	KITCHEN VINYL FLOOR	5/15/2001	5,179	518	10	518		863	50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 279,506	$ 26,219		$ 26,219	$	$ 100,630	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 138,335	$ 14,132	$ 14,132	$		$ 71,114	71
72	Current Year Purchases	79,363	23,173	23,173			23,173	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 217,698	$ 37,305	$ 37,305	$		$ 94,287	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 497,204	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 63,524	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 63,524	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 194,917	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: Omega Healthcare Investors, Inc.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1978	122	6/1/97	$ 232,392	14	14	3
4	Additions							4
5								5
6								6
7	TOTAL		122		$ 232,392 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning 6/1/97
Ending 5/31/2011

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	12/31/2003	$ 234,674
13.	12/31/2004	$ 241,128
14.	12/31/2005	$ 247,759

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 11,561 Description: Please See Attachment 14.1
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Resident transport	1997 Ford Club Wagon	$ 105.67	$ 1,248	17
18					18
19					19
20					20
21	TOTAL		$ 105.67	$ 1,248	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	Line 10a Col 3	hrs	$	9,811	$ 132,453	$ 4,196	9,811	$ 136,649	1
2	Licensed Speech and Language Development Therapist	Line 10a Col 3	hrs		1,923	25,958	1,465	1,923	27,423	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	Line 10a Col 3	hrs		5,887	79,473	1,237	5,887	80,710	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	Line 10 Col 2	# of prescrpts			78,339	22,690		101,029	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Respiratory Therapy IV Therapy & LALT	Line 10a Col 3				8,647	2,100		10,747	13
14	TOTAL			$	17,621	$ 324,870	$ 31,688	17,621	$ 356,558	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 **Report Period Beginning:** 1/1/02 **Ending:** 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 15,334	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	469,869		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	780		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Please See Attached			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 485,983	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	279,506		15
16	Equipment, at Historical Cost	150,600		16
17	Accumulated Depreciation (book methods)	(194,918)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Please See Attached	1,731,325		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,966,513	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,452,496	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (89,788)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	(117,943)		30
31	Accrued Taxes Payable (excluding real estate taxes)	(56,589)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	(53,379)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Please See Attached	(35,477)		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ (353,176)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Please See Attached	(2,017,542)		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ (2,017,542)	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ (2,370,718)	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 4,823,214	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,452,496	$	48

***(See instructions.)**

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,152,788	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,152,788	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(176,981)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Intercompany Eliminations**	2,847,407	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 2,670,426	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 4,823,214	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,731,295	1
2	Discounts and Allowances for all Levels	241,690	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,972,985	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	148,905	6
7	Oxygen	17,407	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 166,312	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,558	13
14	Non-Patient Meals	100	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	14,517	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	30,160	19
20	Radiology and X-Ray		20
21	Other Medical Services	560	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 46,895	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	524	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 524	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Please See Attached	1,730	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,730	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,188,446	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	688,907	31
32	Health Care	1,996,630	32
33	General Administration	1,044,232	33
	B. Capital Expense		
34	Ownership	544,852	34
	C. Ancillary Expense		
35	Special Cost Centers	90,806	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,365,427	40
41	**Income before Income Taxes (line 30 minus line 40)****	(176,981)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (176,981)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,999	2,079	$ 55,666	$ 26.78	1
2	Assistant Director of Nursing	3,992	4,144	86,663	20.91	2
3	Registered Nurses	7,875	8,151	158,687	19.47	3
4	Licensed Practical Nurses	27,171	28,494	446,896	15.68	4
5	Nurse Aides & Orderlies	64,331	67,009	673,223	10.05	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,915	2,051	22,467	10.95	9
10	Activity Assistants	2,875	3,070	17,010	5.54	10
11	Social Service Workers	3,420	3,797	38,154	10.05	11
12	Dietician	2,470	2,572	41,248	16.04	12
13	Food Service Supervisor	8	16	193	12.06	13
14	Head Cook					14
15	Cook Helpers/Assistants	15,689	16,920	111,686	6.60	15
16	Dishwashers					16
17	Maintenance Workers	2,296	2,394	31,099	12.99	17
18	Housekeepers					18
19	Laundry					19
20	Administrator	2,008	2,056	70,271	34.18	20
21	Assistant Administrator					21
22	Other Administrative	6,655	7,345	57,556	7.84	22
23	Office Manager	1,828	2,132	28,949	13.58	23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,976	2,112	39,768	18.83	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	146,508	154,342	$ 1,879,536 *	$ 12.18	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	23	$ 827	1.3	35
36	Medical Director	$1500/mo	18,000	9.1	36
37	Medical Records Consultant	12	3,240	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	163	8,983	10.3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	95	4,461	10.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	293	$ 35,511		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Walker	Administrator	0	$ 69,601
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 69,601

B. Administrative - Other

Description	Amount
Management Fees	$ 92,134
TOTAL (agree to Schedule V, line 17, col. 3)	$ 92,134
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Century Plus	SB Name Badge	$ 214
DSSI	Software house - Direct Supply	1,137
Eproperty Tax LLC	Real & Personal Prop Tax Info	100
Newton Manufacturing	Custom Lapel Pin Mfg.	34
A Place for Mom	Website Subscription	280
Rick Johnson & Co.	Advertising	6
Talina Rubio & Buckley	Legal Fees	25
Gardner Carton Douglas	Legal Fees	150
Duane Morris & Heckscley	Legal Fees	19,949
Invoices Attached		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 21,894

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$
Unemployment Compensation Insurance	
FICA Taxes	
Employee Health Insurance	
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Home Office Employee Benefits	11,537
TOTAL (agree to Schedule V, line 22, col.8)	$ 11,537

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 550
Advertising: Employee Recruitment	6,599
Health Care Worker Background Check	3,778
(Indicate # of checks performed 144)	
A Place for Mom	714
IL Health Care Assoc	5,754
H.O. Dues & Subs / Bank Svc Charges	2,338
Creative Forcasting	48
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 19,781

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 175
In-State Travel	11,823
Regional Travel	
Seminar Expense	
Home Office	5,794
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,792

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SunBridge Care & Rehab-University # 0042697 Report Period Beginning: 1/1/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number SunBridge Care & Rehab-University **#** 0042697 **Report Period Beginning:** 1/1/02 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Healthcare Association $5754.06**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **0**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N\A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **6,940** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N\A**

(9) Are you presently operating under a sublease agreement? **X** YES ____ NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N\A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **69,765**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N\A** Indicate the amount. $ **0**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N\A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ernest & Young** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Financial Statements are consolidated**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.